PART II

DEATH BY A THOUSAND CUTS
A group of doctors were in a restaurant on the North Shore of Massachusetts. The Essex River flowed gently outside. The delicious fruits of the Atlantic Ocean—lobster, clams, mussels—filled their plates. The mood was mellow. They had all safely reached middle age: their marriages and health intact and their kids great (so far, so good).

But Paul, a gentle vascular surgeon, was seething. The other doctors knew what was coming: yet another complaint about a managed care insurer. “You won’t believe what happened to me this week. I checked an elderly diabetic into my hospital. The guy had a lot of troubles. A great guy, but he just can’t manage his diabetes. I had operated on his foot a few weeks ago. And what do you know? As soon as he heals, he goes on a bender. His sugar goes out of control. He was in terrible shape. I checked him into the hospital because I suspected he had an aneurysm (a weakened distention in the wall of a blood vessel). If he tested positive, I knew I had to operate immediately, the next day. That baby could blow any minute and he would bleed to death.

“Well, the PCP (primary care physician) who is my patient’s gatekeeper just called me. Because he represents the HMO, the gate-
keeper has to approve the bill. He thinks I should not have admitted my patient into the hospital for the tests. He questioned my judgment. He told me I was practicing bad, wasteful medicine. He threatened to throw me out of the insurer’s network of doctors if I kept this up. I lost my temper. I told him in no uncertain terms that he just does not understand my kind of medicine. He’s out of his league—out of his depth.”

Bob, a doctor who moonlighted as a gatekeeper for HMOs, asked: “Did you tell the PCP before you admitted the patient that he was being admitted for a test? That you were going to have to operate immediately if the test was positive? Did you ask for authorization?”

“No,” said Paul, his usually quiet voice rising in volume. “Look, this was a life-or-death situation. I had to admit the patient. Immediately. I didn’t have time to ask the PCP for permission. Anyway, how can a PCP possibly evaluate my management of this case? He’s no vascular surgeon. He does not know my patient.”

Jane, another doctor, nodded sympathetically: “He certainly was not very collegial. How could he challenge you like that?”

Paul saved the patient, but he paid a heavy personal price in rancorous, time-consuming interactions with the HMO gatekeeper. Most other doctors have encountered these depressing, negative interactions too—over and over again. Some have retired early, which is a terrible loss for all of us because practice makes perfect, especially in surgery. Meanwhile, lives are needlessly held in the balance as health care providers and HMOs sort out their differences.

The Cultural Imperative

The conversation reminded me of many similar moments in other organizations: “How could he do that? How could she be so stupid, ignorant, assertive?”

I have heard Paul’s plaint many times in the course of the research I’ve conducted for my Harvard Business School case studies and after the lectures I’ve delivered to hundreds of health care groups. I know
from decades of interactions with business organizations that when colleagues cannot communicate with each other without rancor and misunderstandings, when competence and motives are questioned without cause, the organizational culture has gone terribly wrong. In successful organizations, confrontations of this sort lead to intervention and analysis by upper managers, and ultimately to a plan to correct the problem through new processes, incentives, or education; but in most managed care organizations, this kind of culture does not exist.

If Paul and his HMO gatekeeper had been in a success-oriented work environment, they would have met, perhaps with a manager, to clarify the source of the problem and develop a remedy. Likely they would have agreed that their confrontation occurred because the surgeon and gatekeeper lacked a clear organizational relationship and common information. But these two were not working in this kind of organization.

Here’s how a successful health care organization handled a similar problem.

Joan is the Oklahoma-based technical specialist for a firm that manufactures life-support equipment. She is notified that the device in a Louisiana hospital is not working properly. The hospital has no backup and has tried all the usual remedies to no avail. This too is a life-or-death situation that calls for immediate action. But, unlike Paul, who had to “consult” the PCP before he could act, Joan can proceed to do what she knows to do: she e-mails a request to her manager for permission to ship an expensive replacement device ASAP. Permission is expeditiously granted. She also knows that if she does not receive a response within 15 minutes, she is authorized to proceed on her own. Here, everyone cooperates: all efforts are properly focused on the right and expeditious thing to do for the patient’s well-being.

Why are these two situations so glaringly different? It is not the existence of clear procedures in one case and not the other. They could have made a difference, of course. But the core difference is that Joan’s organization has a culture that lends itself to the development of such protocols and Paul’s does not.
People in an organization whose culture relies on a shared vision are positive and action oriented rather than negative and blame oriented. They want to work things out, find solutions, and serve their customers. The culture promotes a shared vision of the beliefs, goals, and activities of the organization. The culture helps them realize that a confrontation is not a clash of personalities, but rather a sign that something deeper is going wrong and a signal that it must be fixed to preserve the organization’s ability to perform its mission.

In health care, a productive organizational culture means finding ways to help patients. But such cultures have become rarer and rarer in managed care organizations and hospitals for reasons that we will explore in this chapter and throughout the book.

Jack Morgan died while he was enrolled in an HMO, the kind of health plan that was once widely touted as the model for the rest of the world’s health care systems. The HMO endlessly delayed his transplant. A culture that had lost its focus was responsible for his death.

The Death of a Man Who Should Have Been Saved

As you know, Jack Morgan is an amalgam of many patients. I was inspired to create him after I read about the momentous failure of the California-based Kaiser HMO kidney transplant program in 2005 and 2006 in the federal government’s reviews and California news sources. The failure paralleled Kaiser’s transformation from an efficient, caring organization focused on delivering high-quality health care at a reasonable price to a confused, bureaucratic business. In 2005, 112 of Kaiser’s kidney transplant candidates died.

The disaster began to unfold prosaically, as most disasters do. Kaiser decided to perform kidney transplants in its own hospitals instead of continuing to send its patients to the non-Kaiser kidney transplantation programs that it had been using, such as those of the University of California (UC) San Francisco and Davis hospitals. (At the time, Kaiser had empty beds and operating rooms because minimally invasive surgical techniques had decreased the demand for them.)
vertically integrated organization, consisting of a health insurer, 30 hospitals, and 12,000 doctors under one umbrella, Kaiser felt it could do a better job of coordinating care by working within its own network of hospitals and doctors. This kind of decision arises so routinely for vertically integrated firms that it is often referred to in business shorthand as the “make-versus-buy” decision: Do I make something myself, using my own facilities, or buy it from an outside vendor?

The HMO notified the more than 1,500 patients awaiting transplants of the change in mid-2004. Ironically, the head of Kaiser’s transplant service noted at the time, “We should be able to achieve higher outcomes.” Instead, outcomes (health care speak for “results”) dramatically worsened. Kaiser’s new program performed only 56 transplants in 2005, while in the previous year, when transplants were still being outsourced, it had performed 165. Twice as many of Kaiser’s patients died as had transplants, while in the rest of California, twice as many got their transplants as died.

Here is one patient’s view, as described by the *Los Angeles Times* in its Pulitzer Prize–worthy coverage of this scandal:

“I don’t know what’s going on here,” Bernard Burks wrote to Kaiser Permanente’s kidney transplant program last October, “but whatever it is, it’s wrong.”

Burks, 56, was among hundreds of patients forced to shift to Kaiser’s new San Francisco program about a year earlier. . . . He feared that his chances of getting a kidney were slipping away.

His daughter was willing to give him one of her kidneys—a good match—to rescue him from grueling rounds of dialysis. But no one at Kaiser seemed to care.

Months passed and he grew increasingly agitated. The transplant coordinator handling the case “is worth about two dead flies,” he wrote in March to the program’s medical director.

Kaiser staff hadn’t read their own files, he continued: “You stated in your letter, ‘If you have a family member or friend who might want to discuss donation of a kidney for you, please have them call us.’ Check your damn records. It appears you are a bunch of incompetents who fail to communicate with each other.”
News about the flawed start-up of Kaiser Permanente’s Northern California transplant program . . . has unleashed bitter recollections and powerful emotions among patients who say that for months they have had their appointments inexplicably canceled, records lost and pleas met with eerie indifference. . . .

“I don’t want those guys cutting on me now,” said Burks, a real estate appraiser in the Sacramento area. “I’m afraid. . . . I just don’t trust them.”

. . . Burks’ daughter . . . said she didn’t mind the repetitive tests and screenings she had to undergo to be his living donor.

“No,” she said, “it looks like they were stalling.”

She began questioning what was going on at Kaiser after she learned that transplant staffers were trying to convince her father that she didn’t really want to donate a kidney to him, citing her move to Texas.

“My dad didn’t even want my kidney, and that made me want to give it to him even more,” she said. “They’re trying to make him think I don’t want to do this.”

Like her father, she no longer wants the transplant performed at Kaiser. When a Kaiser representative called this week, she said she told her: “I’m not doing it with you guys. We’ll mortgage the house, and we’ll just get it done elsewhere.”

In May 2006, the Los Angeles Times reported that Kaiser caused many patients to miss opportunities for a transplant solely because of improperly handled paperwork: fewer than 3 percent of those on Kaiser’s waiting list got transplants, as compared to 12 percent elsewhere in the state. One hundred twelve people died while waiting on its transplant list. Some of those waiting for a transplant had offers of kidney donations from relatives, so there was no need to wait for a donor kidney to become available; but UC San Francisco alleged that in 25 cases of a perfect match, the Kaiser HMO refused to outsource the transplanting procedure to avoid the delays occurring in Kaiser’s own system.

There were warning signs. UC Davis had warned Kaiser officials that the switch would require patients to wait longer, from 1.5 to 3.6
years, for a transplant; but Kaiser allegedly failed to notify its patients of this observation. Instead, it informed them that they could obtain transplants only at Kaiser facilities (even though Medicare enrollees were insured for transplantation elsewhere).  

When the smoke cleared, the federal government overseers investigating the case concluded that virtually every part of Kaiser’s program failed patients. A clerk with no written evidence of training, for example, was responsible for coordinating highly complex information with organ banks that procured the kidneys for transplant candidates. At one point, there were 1,000 incomplete records of the medical history of these gravely ill kidney transplant patients. Three RNs had little knowledge of the care required for pretransplant patients.  

The report especially faulted Kaiser’s quality control. “There was no evidence that operations and other components of the program were being reviewed and evaluated to ensure the delivery of quality care to patients.” Insiders who complained were fired or placed “on leave.” One kidney specialist simply walked out and never returned. By May 2006, only one specialist was left, a doctor-manager who had been relieved of the administrative responsibilities she once held. Other hospitals typically employed at least four to five transplant nephrologists for this patient load. The HMO’s leadership seemed unaware or unconcerned that its critically ill transplant patients were at risk.  

The head of the transplant program’s lawsuit for wrongful termination was settled by Kaiser without comments. The complaint states that he “discovered that the program was so poorly organized and unprofessionally managed that it failed to comply with state and federal requirements and was compromising patient care, leading to unnecessary suffering and possibly deaths.” After his numerous complaints went unheeded and he was terminated, he felt compelled to alert the media and state and federal regulatory agencies, including the California Department of Managed Health Care, the U.S. Department of Justice, and the Medical Board of California. Lawsuits followed. In early 2007, as I write this, the story is far from over. One other plaintiff alleged that when he expressed his fears
about the damage the delay was causing him because he had already been a dialysis patient for six years, a Kaiser doctor advised him to obtain his transplant overseas.\(^{18}\)

The steady bombardment of media stories and government requirements eventually prompted Kaiser to shut down the transplant program in May 2006 and transfer the patients awaiting surgery back to the UC Davis and San Francisco Medical Centers.\(^{19}\) Kaiser was also required to pay $2 million to the California Department of Managed Health Care, the largest fine in the department’s history, and $3 million to an organ-donation organization.\(^{20}\) But where was the care and concern that should characterize a health service organization? Where was Kaiser’s soul?

The evidence suggests a failure of the managerial system at Kaiser, a failure I attribute to the erosion of the culture of excellence that once made Kaiser a model for the managed care movement in the rest of the industry.

**What Happened to Managed Care?**

All great organizations—families, tribes, companies—are made great by their culture—a shared set of values, expectations, and modes of behavior—forged by a long, closely examined history of successes and failures. In the beginning, Kaiser’s culture was dedicated to delivering high-quality, efficient care to its patients. Its doctors, executives, and enrollees understood that this was not a mere business; it was a movement in which they would jointly manage health care.\(^{21}\) But by the time people like Jack Morgan needed their help, HMOs like Kaiser were more businesses than movements.

Initially, Kaiser was a classic entrepreneurial nonprofit—it did good and it did well. Like so many other social innovations—the environmental movement; the women’s and minorities’ liberation movements; the Salvation Army—it began with the best of motives: to provide cost-effective health care. It managed care through two important innovations: an unusual organizational structure, which
vertically integrated physicians, hospitals, and insurance firms with each other, and prepayment.

Kaiser’s novel integration of providers and insurers was crucially important to its success: it aligned their separate interests in providing good health care and in doing so at an affordable price. (In contrast, as we saw in Paul’s case, independent insurers and providers are typically at each other’s throats because their aims conflict: health insurers that do not own hospitals or employ an exclusive team of doctors aim to minimize medical costs, while health care providers that are not integrated with an insurer want to maximize the use of their services.) Kaiser’s integrated structure helped to align the hospitals’, doctors’, and insurers’ interests in the overall welfare of the organization—good medical care at a reasonable price.

Prepayment was novel and important too. Kaiser’s founders believed that prepaid health care would induce doctors to provide preventive measures and wellness so the enrollee would not get sick. Typically, physicians and hospitals are paid only for treating sick patients, not for keeping them healthy. In contrast, the idea behind the HMOs was that providers who were prepaid for their services would have a financial incentive to keep their patients healthy.

Kaiser was widely cited as the model for the managed care organizations that proliferated in the United States in the late 1980s. Yet, although a few vertically integrated Kaiser clones already existed, most of the new managed care firms were no Kaisers. For one thing, they were not integrated. Instead, insurers merely cobbled together a disparate network consisting of physicians and hospitals that were willing to accept their low payments. The health care providers continued to work for themselves. They were, in effect, contract workers paid to perform particular services who had no allegiance to the insurer. Indeed, providers frequently resented the insurers as a result of the treatment they received, including late and stingy payments and “gatekeepers” to ensure that enrollee patients were not referred to “unneeded” services.

Although the insurers were prepaid for their services, most of these independent providers were not. They had no financial incen-
tive to promote wellness. And even in the cases where the providers were prepaid, the payment was sometimes so stringent that providers felt pressured to skimp even on medical therapies. A doctor who receives an adequate payment per patient is motivated to keep patients healthy. But if the prepayment is too stingy, he may reluctantly decide to skimp on this kind of preventive care.

Some of these kinds of HMOs transformed the managed care movement from social entrepreneurship into the worst kind of business—the kind that injures its customers. Meanwhile, their CEOs became dazzlingly wealthy, with compensation topping even that of other corporate CEOs. Dr. Norman Payson, the CEO of Oxford Health Plans, a firm notorious for its mismanagement with regulators, the health care industry press, and physicians, earned $73 million when the firm was finally sold. I do not begrudge Bill Gates his billions from Microsoft—or any other corporate leader’s compensation from creating wealth and opportunity. But I do begrudge the millions earned off the backs of patients, who were denied the services that are rightfully theirs, and doctors, whose autonomy and spirit were broken.

At their end, managed care executives believed that their networks—that is, groups of doctors and hospitals—were the keys to their success. With the right network, groups to which they paid relatively low prices and that were acceptable to enrollees, the managed care firm would flourish.

No. Wrong.

By accepting this simplistic abstraction, the insurers ignored the many complex, diverse interactions that must guide the applications of medical principles to an individual.

And in the process they helped Jack Morgan to die prematurely.

It’s the Culture, Stupid

George H. W. Bush began his 1992 reelection campaign in the warm glow of a dazzling U.S. military victory in the Persian Gulf War. He was a sure bet. After all, Bush was a military hero, a patrician
Yale Phi Beta Kappa, a true public servant, whereas his opponent was the virtually unknown governor of one of the nation’s poorest states, tarred with unsavory allegations of sexual and financial transgressions. But Bush lost the election to his opponent, William J. Clinton.

What happened? As Clinton’s political advisors crowed, Bush missed the obvious: “It’s the economy, stupid.” The U.S. economy was in the doldrums, and Americans vote for their pocketbooks.

Many smart people replicate Bush’s mistake: they miss the obvious. Those who believe that mere organizational structures and characteristics such as a network are the key to performance similarly miss the obvious. It is, above all, the culture that counts.

In many organizations, the culture—an attitude, a way of doing things, a set of values—is so deeply internalized that it is not readily observable. Nevertheless, it is the key to their success. The Salvation Army, for example, has survived for more than a hundred years as a missionary organization that provides loving care to the destitute in part because of its culture—many of its members consider themselves soldiers in God’s Army. When cultured organizations become uncultured—by distancing themselves from their internalized values, attitudes, and approaches—they fail. Consider Enron, which drove amazing growth through its entrepreneurial culture as an energy trading firm. But when its executives fell in love with their bonuses, their skyrocketing salaries, and their images as portrayed on Wall Street and elsewhere, they sought endless expansion in earnings, leading to the erosion of their culture.

When health care organizations lose their culture, they can kill people in the process.

The Care and Feeding of Culture

What is culture? Where does it originate? How does it sustain itself?

All cultured organizations are essentially religious—they may not revolve around God, but they hold a core set of spiritual values that inform their actions. What can we learn about the formation of cul-
ture from the formation of a religious organization? How does a group of people come to share a set of values that are so powerful that they can be maintained across centuries and geographies?

As one example, let us examine the history of the Israelites, a group whose culture has long survived despite its members’ geographical dispersion and nomadic existence. This culture was forged during the 40 years that Moses led the Israelites in the desert. It was strengthened by successful responses to external and internal challenges.

Consider, for example, the effect on the Israelites of the pursuit by the Egyptians. At first, they cry:

Let us alone that we may serve Egypt!
Indeed, better for us serving Egypt
Than our dying alone in the wilderness!
(Exodus 14:12)

But after Moses leads them to safety through a sea, “the people trusted in God and in Moses his servant” (Exodus 14:31).

The desert itself, parched and desolate, helped to forge the culture. So did responses to internal challenges. When the monotheistic Hebrews strayed and worshiped multiple gods in heathen fertility rites, for example, the Bible approvingly recounts that one of Moses’ followers thrust a javelin “through the man of Israel, and the woman through her belly” (Numbers 25:8).

Culture does not inevitably require charismatic leaders. When God commands a stuttering Moses to lead the Israelites out of Egypt, for example, he pleads:

Please, my lord,
No man of words am I . . .
For heavy of mouth and heavy of tongue am I!
(Exodus 4:10)

But Moses is a good leader—one with a steadfast vision. Born an Israelite, raised as an Egyptian prince, forced to flee Egypt to main-
tain his identity, Moses had the clarity of vision of those who define themselves. And, as in all successful cultures, he did not work alone. He forged powerful alliances with people who had complementary skills: his eloquent, weak brother Aaron and his ferocious enforcers, the sons of Levi. His ultimate ally becomes his successor—the clever, courageous Joshua, who leads the Israelites out of the desert.

Myth or reality? Considerable archeological evidence supports the major elements of the story told in Exodus; but even if the physical evidence were absent, the psychological elements of the story ring true. It seems right that cultures are formed from an unusual point of view, refined and strengthened by external and internal challenges, and led by a group of people with complementary skills. Failures and hardships define a culture as much as its successes. The culture survives its immediate leaders and is passed on from one generation to the next, in part through continual repetition of the pivotal events in its formation.

The Cultured Kaiser Permanente

All of the key positive elements of culture were present in the early days of the Kaiser Foundation Health Plan. It too was founded in the desert, in the 1930s, by flawed leaders who had complementary skills. It too was strengthened by numerous internal and external challenges. By 1992, Kaiser was so widely admired that it served as the model for President and Hillary Clinton’s national health care reform initiative.

Sound evidence supported their enthusiasm for Kaiser. It was among the largest health care providers in the United States—covering more than 9 million people in 1995—and it was rated among the country’s best HMOs by popular consumer publications. Kaiser’s excellence was also evidenced by its size: had it been a public corporation, its 1992 revenues of $11 billion and profits of $796 million would have placed it forty-third on the list of the Fortune 500.
Out of the Desert

The early version of Kaiser developed its culture the old-fashioned way: it earned it, building it up over the years and supporting it with the investment of billions of dollars. Its founders had a long and productive history of collaboration, as did its other principals. Like the Israelites, who, after 40 years of wandering in the desert with Moses, developed a clear, cohesive identity, these early Kaisersites literally lived together in the desert for five years in the 1930s and in geographically isolated sites during World War II. External challenges from hostile medical associations and Communist witch hunter Senator Joseph McCarthy, as well as internal challenges from dissident physician groups, strengthened the organization. Failures helped to clarify its culture as much as successes did.

As told by John G. Smillie in *Can Physicians Manage the Quality and Costs of Health Care?* the story begins, in 1933, with Sidney Garfield, an entrepreneurial physician who, in the Mojave Desert, built a hospital and employed doctors to provide health care for the workers who constructed the Los Angeles aqueduct. Virtually from the inception of his career, Garfield was a practical businessman. He insisted, for example, on prepayment for his services: “The insurance companies held the money but they were anxious to keep it. We would treat a patient with tender loving care and, more often than not, the (insurers) would discount our bill, saying we had treated the patient too many times.” Later, Garfield learned that prepayment also motivated doctors to try to correct problems that could create the need for more expensive health care in the future. This mindset applied even to safety concerns outside doctors’ usual realm of activity. For example, to avoid head injuries caused by loose rocks in the aqueduct, Garfield convinced the contractors to shore up areas he identified as dangerous.

At the end of the aqueduct project, Garfield had managed to accumulate $250,000 in profits (at a time when the average annual wage was $1,350). Garfield’s tight rein on the purse strings was legendary. For example, “employees could obtain a new pencil only if they turned in a pencil stub of three inches or less. A Pencil Stub Club
rewarded those who had served the organization for 35 years with a stub-shaped lapel pin.” Recalls an observer, “This period of stringent economy established a pattern of frugal allocation of resources that persisted even into more prosperous years. Formed by these early economies, the physicians and staff, as a matter of institutional culture, continued to abhor waste.”

Garfield imbued this culture in the physicians who worked for him, some of whom he had met as fellow medical students. For example, Garfield’s physicians worked six days a week on one project, but “there was no complaining.” For one thing, the physicians formed a tight social group: “We picked people who liked each other—we felt like we were enjoying ourselves.” For another, Garfield was one of the guys; he worked alongside the other physicians and continually sought out their advice about new ideas. Garfield understood the importance of this culture, although likely he didn’t use the word. For example, he attributed the failure to provide cost-effective health services in one project to people who “were not interested in making our plan work.”

The five-year sojourn in the desert laid the foundation for the organization’s culture, which balanced health care quality and costs, and for the lifelong business partnership between Garfield and industrialist Henry J. Kaiser. They joined forces after the aqueduct project when Kaiser tapped Garfield to set up a similar project during construction of Grand Coulee Dam. Garfield, a reserved, enigmatic physician, was drawn to the ebullient, expansive Kaiser, a man who claimed he could accomplish the seemingly impossible. Kaiser, who saw himself as a benevolent employer, wanted Garfield to provide health care to his workers in various geographically isolated construction and World War II defense contract sites.

Both men were self-created. Garfield was the son of Jewish immigrants whose self-creation even extended to fashioning a new surname. Kaiser, for his part, had abandoned his home and school after the eighth grade to seek his fortune. He ultimately built an empire based on his organizational skills: construction, ships, steel, cement, autos, hotels—he did them all. “Rome wasn’t built in a day,” he bragged, “because the Romans didn’t give us a contract.”
The bond between the two ran deep, so deep that it cries out for a Freudian analysis. Garfield always referred to Kaiser as “the boss” and docilely concurred with Kaiser’s critiques of his management style: “Mr. Kaiser doesn’t have any confidence in my ability to manage the program, and everyone agrees [that] . . . strong leadership hasn’t emerged yet.” Eventually, he even became Kaiser’s brother-in-law, despite the 24-year difference in their ages, marrying the sister of Kaiser’s second wife.

After Garfield successfully provided health care to Kaiser’s workers during World War II, he established a private prepaid group practice. Only the true believers joined him: in Northern California, that meant a scant 13 physicians who would form the core of the new practice. In 1945, the nonprofit Permanente Health Plan was formed. Garfield, who owned the physicians’ group and headed the hospitals owned by the Permanente Foundation, effectively ran the show, although the Henry J. Kaiser Company had formal control.

Garfield’s unilateral management became increasingly untenable as the organization grew. In 1948, he withdrew from administration of the medical group. He noted, “I did this with complete faith—blind faith—that these changes would not alter the situation. We doctors had conceived the plan, developed it, sacrificed for it, made it work, and believed that it was going to remain in operation.” Garfield knew he had developed a culture that would survive him.

**Strengthened by Fire**

The belief in the virtues of a prepaid managed care group was strengthened by the attacks of medical societies that routinely rejected Permanente physicians for membership. The independent doctors viewed the Kaiser physicians not only as economic threats but also as compromisers of physician independence because they permitted a nonphysician board to control them. The societies also questioned whether prepayment would motivate physicians to provide fewer services than needed. These attacks backfired, however. For example, Paul de Kruif, a well-known author whose son was a
Kaiser doctor, defended the organization in a series of widely read *Reader’s Digest* articles, thus bringing it to the sympathetic attention of the public.

The charges of Communist ties among Kaiser physicians, which began in the late 1940s and intensified during the Senate investigations chaired by the Communist witch hunter Senator Joseph McCarthy, also strengthened the organization. When Henry Kaiser fired three physicians because of his concern that the charges levied against them would compromise the Kaiser Company’s defense contracts, the medical group urged increased self-governance. As one physician skeptically observed, the Kaiser higher-ups “were telling us what a good job we were doing but [that] really we ought to spend our efforts in taking care of the patients . . . and they would run the business. We had sense enough to feel this wasn’t quite right. Providing medical care was itself a business.”

Yet the medical group’s attempt to build its own vertically integrated system in San Diego, complete with hospitals and health plan, floundered. The physicians learned that they needed the culture engrained in Kaiser’s hospital and insurance arms to succeed. Similarly, when Henry Kaiser tried and failed to replicate the system in Hawaii by converting five successful fee-for-service physicians to a medical group style of practice, he was forced to bring in the true believers—Garfield and his prepaid group practice acolytes from California.

These failures were deeply etched into the organization’s consciousness: the three components of the organization understood how much they needed each other and forged ways to work together.

**Kaiser Permanente’s Culture Disintegrates**

The founders of Kaiser Permanente and its culture had a novel vision: prepaid health care services delivered by an integrated troika of insurers, medical groups, and hospitals. This cultured organization achieved great financial and medical success. And deservedly so.

Kaiser’s 1992 selection by some health care reformers as the model for the U.S. health care system seemed like its apotheosis. Instead,
that year marked the beginning of a period of turmoil and decline for the organization.

By October 1997, Kaiser’s chief financial officer announced the company’s first-ever loss, which she estimated at $30 to $50 million. She proved embarrassingly wrong. The loss for the year turned out to be $270 million. An organization’s inability to forecast its earnings correctly is usually viewed as a serious problem, perhaps even more serious than a loss in itself, because it frequently indicates a fundamental lack of managerial control.

And indeed, there were other signs at that time that the fabled Kaiser had lost its way.

To implement an ambitious growth strategy, Kaiser had abandoned its adherence to prepayment, to integration, and to physicians and hospitals who believed in managed care. In 1994, the organization’s chairman deplored legislation that would have required Kaiser’s plan to abandon its medical groups and include any provider willing to accept Kaiser’s fee, noting that it “would seriously undermine or eliminate our ability” to provide high-quality, cost-effective care. But by 1998, he introduced a systemwide health insurance plan that enabled enrollees to visit non-Kaiser doctors for additional fees. Indeed, in some areas, Kaiser’s insurance plans had no doctors who were exclusively affiliated with them.

To staff its growth, Kaiser sought out new managers (one estimate placed 50 to 60 percent of its top managers as new to their positions and 20 to 30 percent as new to the organization) and new acquisitions. For example, Kaiser purchased health plans from public for-profit HMOs, like Humana, that had little ideological kinship with its nonprofit insurance plan. By 1998, Kaiser’s chairman acknowledged that many of these expansions were spin-off or sale candidates because of substantial losses, up to a billion dollars.

Kaiser’s problems were not solely financial. The quality of care in its Texas plan triggered a critical report by the state insurance department, later settled by a fine. Kaiser subsequently sold the plan. When the Texas plan’s assets were sold in 1998, the buyer did not pick up obligations for its malpractice suits. A California state inspection found serious deficiencies in its hospitals. Labor problems
abounded too. Thousands of unionized Kaiser workers picketed the organization. A nurse at Kaiser’s Oakland facility who was not bound by gag rules noted, “We’ve watched the quality of care go downhill.” The California Nurses Association successfully struck against Kaiser, in part because of its concern that the organization was spending $60 million on marketing while laying off nurses. Doctors were unhappy too, some even proposing affiliations with other plans.

Kaiser’s explanations for these problems followed the PR 101 lines of firms that are in denial: the loss? “We missed the price turn in the industry.”36 Employee and quality problems? “That’s a flat lie. These are human systems. . . . They don’t work because there are honest mistakes.”37 Problems in Texas? “The media often focus on isolated incidents that are unrelated to the things being done to make the organization stronger.”38

But Kaiser’s problems indicated a profound problem, one much more fundamental than errors in human systems or forecasting costs: Kaiser had strayed from its cultural roots. Kaiser’s growth strategy caused membership to soar, but it nearly lost its soul in the process. The culture-imbued physicians, the hospitals man-aged directly by Kaiser, the seasoned insurance officials who worked with the providers to balance health care quality and cost, the tense interplay among the three elements of the system—all of these were diminished in a growth strategy in which Kaiser embraced physicians it did not know, hospitals it did not manage, and geographical regions whose politics and populace it did not fully understand.

Do not get me wrong. I do not question the intelligence, energy, honesty, or motives of Kaiser’s management. But growth at the expense of culture vitiates the elements that establish a company’s success. It is like building a flashy home extension without a foundation. Absent the financial and health care quality controls internalized by the Garfield-era doctors, managers, and their progeny, their shared history and sense of purpose, such losses and allegations of quality problems are no surprise. As Sidney Garfield prophetically noted: “If you don’t have the . . . groups who have it in their hearts to make it work and who believe in prepaid practice, it won’t work. This is the thing that makes me wonder about HMOs all over the
country. They aren’t going to work unless they get men who really believe in giving service to the people.”39

Corporate Managed Care: Straying from the Kaiser Culture

As it matured, the managed care movement cast Kaiser’s integrated model by the wayside. After all, building hospitals and financing doctors’ groups, as Kaiser had done, required billions of dollars of investment, and developing a corporate culture required decades of time.

The new moguls of managed care did not have this kind of time or that kind of money: they could not rely on a deeply embedded culture and an integrated doctor-hospital-insurer organization to craft better, cheaper ways of delivering health care. Instead, they controlled costs by “just saying no”: no to payments to providers; no to requests from enrollees for referrals to specialists; no to hospital admissions—no, no, and no some more. At the peak of managed care’s sway, in 1999, far more physicians were financially rewarded for productivity by the insurers than for patient satisfaction.40

A managed care organization with the unintentionally ironic name of U.S. Healthcare exemplified this new breed of HMO. Formed as a nonprofit organization funded by a government loan, it did not take long for its CEO to figure out that there was gold in them thar managed care hills. Six years after its founding, U.S. Healthcare was a publicly traded company, renowned for its low prices, attained with the metaphorical brass knuckles it wore when reimbursing providers. In a key market, its practices so worried a competitor, a traditional health insurer, that it took out ads to decry U.S. Healthcare’s strict, severe gatekeeper rules for referrals to emergency rooms and specialists. Bad mistake. When U.S. Healthcare sued, guess who won?41

By 1996, Aetna, another traditional health insurer worn down by competition with these managed care start-ups, purchased U.S. Healthcare for $9 billion. U.S. Healthcare’s founder, a pharmacist, earned nearly a billion dollars in the process. Aetna was so confident that its purchase would enable it to expand U.S. Healthcare’s success that it exited all other product lines, such as property and casualty insurance.
Although these new managed care organizations were no Kaisers, most of the academic health care policy world was delirious about their prospects. The academics believed that big systems and big organizations were needed to oversee individual physicians. They questioned the health care quality and cost controls of doctors who worked for themselves in small groups. The new organizations’ just-say-no version of managed care met the academics’ view of appropriate health care because it meshed with their technocratic skills of evaluating the cost-effectiveness of medical care.42

In November 1999, *Health Affairs*, a leading academic health care public policy journal, published a lengthy, fawning interview that allowed Aetna’s CEO to share his wisdom with its academic readers.43 The interviewer seemed oblivious to the fact that Aetna’s hardball managed care practices were widely excoriated by patients and providers. As Aetna’s reputation soured, along with those of other managed care players, its share price tumbled.44 Very soon after the laudatory *Health Affairs* interview was published, Aetna’s CEO was forced to resign.45

The academic touting of the virtues of managed care convinced politicians as astute as former President Bill Clinton and his wife, New York Senator Hillary Rodham Clinton, for a while to go out on a limb in support of plans like U.S. Healthcare; but doing so turned out to be a costly mistake. They did not appreciate the public’s and doctors’ disdain for this kind of “just-say-no” health insurer. They failed to achieve their plan to offer universal health care coverage in the United States, in large part, because they chose managed care as its centerpiece.46

**HMOs Are Market Driven? Huh?**

To promote their adoption by a skeptical public, managed care firms like U.S. Healthcare were touted as “market-driven” clones of Kaiser that would compete with each other to make health care better and cheaper; but, in truth, most of them were controlled by third-party technocrats rather than entrepreneurial providers. They were miles
apart from the original version of Kaiser, whose providers were intent on re-creating health care so that it responded to consumers’ needs for efficient, personalized services.

Market-driven industries rely on interactions between customers and providers, supply and demand. Picture the dynamic retailing industry as a model of this interaction. In retailing, companies have succeeded when they have paid attention to some unfulfilled consumer need, such as Target for fashion-conscious budget shoppers and Whole Foods for the organic set, and they have failed when they have stopped listening, like Kmart. But with this new breed of managed care, patients and doctors were minor players. Nobody listened to them. Instead, a third party, a gatekeeper, controlled all the action.

Technocrats can only ration what exists; they typically lack the business and medical skills, vision, and daring needed to create new, better ways of delivering health care. They are not entrepreneurial: technocrats can say yes or no, but they cannot create innovations. The technocrats’ notion of managing health care involved reducing payments to hospitals and doctors and weaning consumers away from wasteful, expensive specialists. As one analysis noted, “Most (but not all) HMOs have not accomplished what their proponents had promised: changing clinical practice processes and improving quality of care relative to the existing system.”

These technocratic managed care policies were so widely deplored that they became the stuff of humor. For example, one Web site posted the following satirical headline:

**New HMO Strategy: Pay Health Claims**
**Analysts Skeptical; Doubt Insurers Equipped to Handle Job**

Minneapolis, Minn. (SatireWire.com)—Moving into what insurance executives concede is “uncharted territory,” five of the nation’s leading HMOs announced yesterday they will begin paying health insurance claims for sick and injured people.

To most Americans, HMOs had the cold, hard heart of an underripe cheese.
Managed care’s just-say-no strategy is generally conceded to be a failure. Nevertheless, academic die-hards continue to point to past reductions in the annual increases of the insurance premiums paid by employers as evidence of managed care’s efficacy. For example, some attribute the drop in premium inflation from 1993 to 1996 to the effect of managed care.49

But the role that managed care played in causing this reduction is questionable. After all, many other cost-reducing events occurred during this period too. For one, general inflation dropped dramatically—the consumer price index declined by nearly 50 percent from 1993 to 1998.50 And, from 1997 to 1999, the U.S. government’s massive Medicare health insurance program for the elderly put harsh new payment rules into effect, which caused providers to decrease their costs substantially. For example, Medicare’s payment rate per beneficiary declined by about one-third for home health costs and by 5 percent for outpatient hospital costs.51 These payment declines caused suppliers to reduce their costs, not to shift them to other insurers. To the contrary, during this period, Medicare paid providers 100 percent or more of its costs.52 Last, to gain market share, some insurers incurred significant underwriting losses during this period, effectively decreasing their prices by absorbing cost increases.53 For example, the Blue Cross and Blue Shield plans that earned a small profit in 1994 experienced losses of 1.2 percent in 1997.54

In other words, the 1990s reductions in the inflation of health insurance prices paid by employers should not be credited solely, or even primarily, to the impact of the just-say-no managed care insurers. The reductions were also affected by the generally lower level of inflation in the economy, cost-reducing pressure on providers from Medicare, and price competition among insurers, who were willing to incur losses in an attempt to gain market share.

The Managed Care Phoenix: Rising from the Ashes

It did not take long for the just-say-no version of managed care to unravel. Health insurance plans that provide easier access to spe-
cialists and hospitals now dominate. These preferred-provider-organization (PPO) plans enable enrollees to use the doctor or hospital of their choice for a higher price or use the “preferred providers” for a lower price.

Yet even as their just-say-no strategy was coming apart at the seams, managed care organizations retained a considerable part of their expensive gatekeeper infrastructure. This time around, they promise to control costs by actually managing care, especially for the victims of chronic diseases and disabilities, rather than just saying no. “Disease management” is their new mantra.

But the current version of managed care is unlikely to manage health care any more effectively or efficiently than the old just-say-no one. There is no accepted evidence of the cost effectiveness of disease management. Managing the delivery of health care services is the right idea, especially in the case of sick people, like Jack Morgan, because most health care costs are incurred by people who suffer from chronic diseases and whose care is mismanaged. There are considerable opportunities to innovate medical care, as described in Chapter 7; but insurers are unlikely agents of these changes. The fundamental premise of a top-down strategy in which an insurer manages how hundreds of thousands of independent physicians, multi-billion-dollar medical technology firms, and thousands of hospitals deliver medical care to millions of people is dubious. It is as questionable as the premise that automobile insurers can rescue the U.S. automobile industry by telling manufacturers how to make better, cheaper cars.

Can you imagine GEICO, the automobile insurance company, asserting that it can manage the sickly automotive manufacturers, Ford and General Motors, back to health? Of course not. GEICO may be a wonderful automobile insurance firm, but its executives would probably quickly admit they do not know how to make cars. Health insurance executives and their academics groupies, however, lack this kind of self-awareness and humility. Filled with hubris, they moan and groan about the providers’ “low compliance” with the insurers’ care management advice, mysteriously baffled by the
reluctance of independent professionals who are legally liable for the quality of care to “comply” with the strictures of health insurance officials who not so long ago made these professionals’ lives a misery.57

Productivity gains arise primarily from innovations driven by entrepreneurs. Productivity rises organically, not technocratically. We celebrate Thomas Edison, Henry Ford, and Sam Walton because they transformed how energy was used, cars were manufactured, and goods were sold. We do not celebrate them because they muscled down their suppliers’ prices and barred consumers from needed goods. Entrepreneurs, not bureaucrats, create the innovations that increase productivity.

At this point, reductions in health insurance premiums are a relic of the past. The underwriting losses incurred in 1998, 1 percent in the case of the Blues, were the last straw. Health insurers have since raised their rates in successful efforts to restore their underwriting profitability.58 Meanwhile, underlying health care costs have shot up once again.

Back to Basics: What Is Health Insurance All About?

If the just-say-no policies and other costly, ineffective, top-down strategies of the managed care form of health insurance help to kill patients like Jack Morgan, what are the alternatives? We cannot do without health insurance. We need it primarily to protect us financially if we incur medical costs that are catastrophically high.

The first health plans for U.S. workers were designed to do just that. They compensated victims for loss of income when an accident or illness caused extended disability. In 1863, Travelers Insurance Company offered death or permanent disability benefits, and in 1899 Aetna and Travelers sold a temporary disability plan “occasioned by all diseases except tuberculosis, venereal disease, insanity, or disabilities due to alcohol or narcotics.” The first business-based group plan, organized by Montgomery Ward in 1910, was cut from the
same cloth, intended to protect workers from the financial consequences of loss of income due to catastrophic illness.59

How can we get health insurance plans that protect us against bankruptcy without subjecting us to the oversight of managed care gatekeepers? One simple way is to change their coverage.

Recent innovations in the design of health insurance policies illustrate the potential impact of this different kind of health insurance. A 2006 analysis of new health insurance plans that required the enrollees to pay up to $2,000 out of their own pocket before insurance coverage began found that their premiums were up to 35 percent lower than plans that offered comparable benefits and that their costs grew at significantly lower rates.60 Separate analyses revealed that enrollees in such plans—called “high-deductible plans”—used health care resources in significantly different ways, when compared to their usage patterns before they were enrolled in a high-deductible plan and to a matched control group: they used less of the emergency room and hospital and fewer drugs and yet engaged in more preventive care, such as yearly physical examinations. Those who had chronic diseases complied more with the drug regimens that are key to their health status.61

When the consultancy McKinsey asked the enrollees in these high-deductible plans why they had improved their health care behaviors, they answered, “If I catch an issue early, I will save money in the long term” at significantly higher rates than a matched sample of those with conventional insurance plans.62

Traditional plans were called “first-dollar coverage” because they paid for virtually all the expenses of the care provided by doctors and hospitals, not only the expenses that we could not afford. These insurance plans were begun during the depression to protect the providers’ income, not ours. At that time, several hospitals initiated prepayment plans to guarantee their revenues, and, in 1939, doctors organized the Blue Shield insurance plans to pay for physician fees in hospitals.

But as these plans proliferated, concerns began to arise that these “first-dollar-coverage” health insurance policies disconnect the user
from the cost of health care. Fully insured patients might feel that their health care is free and become careless about how much they use or whether a provider gives them good values. After all, the nation’s largest health insurance plans, Blue Cross and Blue Shield, were created by doctors and hospitals to protect their income. Yet, the conventional wisdom among health economists was that insurance had little to do with the growth in the cost of health care. Two analysts, for example, concluded that technology was the primary cost driver. They pegged the impact on the costs of health care on pocketbook issues, such as prices or income, at only around 20 percent.63

But a recent analysis, conducted by MIT economist Amy Finkelstein, suggests quite the opposite. She found that the increased availability of Medicare insurance funds accounted for more than half of the growth in health care spending between 1965 and 1970. Medicare increases caused new hospitals to enter and existing hospitals to expand their capacity. Further, the increased supply of hospital capacity may well have spilled over to those enrolled in other forms of insurance and increased their costs as well.64 (Her results differ from the conventional wisdom because she examined the response of supply to increased demand, over a longer period of time.)

What did we receive for the increased expenditures induced by increases in health insurance? Finkelstein’s analysis reveals no impact on death rates.65 The only benefit she found was that out-of-pocket spending by the heavy users of health care declined substantially. In other words, the increased availability of first-dollar-coverage insurance induced a large increase in spending with no discernible impact on death rates. The only corresponding benefit of providing the insurance was that of reducing out-of-pocket spending by the heavy users of health care. Had we simply paid their out-of-pocket needs directly, rather than with Medicare insurance benefits, total health care cost increases would have been significantly lower.

Finkelstein’s analysis has important implications for the design of health insurance policies. It suggests that an alternative strategy to managed care is to permit consumers to manage their own demand
by exposing them to more of the costs of health insurance, while protecting them against catastrophically high expenses.

What do you prefer? Insurance plans that motivate consumers to manage their health care or those that rely on third-party technocrats to do so?

High-deductible plans are only one example of health insurance plans that rely on consumers and doctors, rather than on technocrats, to manage their health care. In Chapters 7 and 8, we will examine the rich variety of consumer-driven health insurance plans that already have been created, even though the U.S. consumer-driven health care movement is in its infancy.

For Want of a Nail, Jack Morgan Died

At one time, the fabled HMO Kaiser exhibited a corporate culture that enabled it to offer high-quality health care at a reasonable price, and Kaiser still does a good job for many of its patients. But when Kaiser’s managers decided to grow the organization, they wore down the foundations of this culture and lost a fortune in the process.

In all human activities, God is in the details, especially when it comes to taking care of seriously ill people. The management of the Kaiser HMO allegedly neglected these thousands of details in its kidney transplant program: it reportedly understaffed the program, fired or ignored employees who complained about its quality problems, and provided little support or training for those who remained. In 2006, after more than a hundred of the patients awaiting kidney transplantation died, Kaiser performed one merciful act: it closed the program.

Jack Morgan had little choice. He did not want to enroll with an HMO; but his only alternative to it was to become uninsured because his state regulated small business’s health insurance heavily. Jack purchased insurance so that the HMO would keep him alive if he became sick.
But, instead, he got death. The insurer simply did not perform the transplant.

But why did Jack not simply pay for the kidney transplant out of his own pocket? After all, he was a solidly middle-class guy.

Jack knew that he could not afford to pay the price of a kidney transplant out of his own pocket. U.S. hospitals are far more expensive than those in other parts of the world. He knew that these hospitals charge their highest prices to the uninsured and that requests for discounts are often ignored. To the contrary, the hospitals would likely confiscate everything he owned if he failed to pay these high prices.

The story of how our hospitals, most of them nonprofit, became so bloated and greedy is told in the next chapter.